		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. **IDPH Facility ID Number:** 0016147

Facility Name: D'ADRIAN CONVALESCENT CENTER

Address: 1373 D'ADRIAN PROFESSIONAL PARK (Number) GODFREY (City) 62035 (Zip Code)

County: MADISON

Telephone Number: (618)466-0153 **Fax #** (618)466-0190

IDPA ID Number: 37-0955244001

Date of Initial License for Current Owners: JUNE 1972

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: JERRY W. JENNINGS **Telephone Number:** 217 787 - 8530

II. **CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) JERRY W. JENNINGS

(Title) CONTROLLER

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Print Preview

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	29	Skilled (SNF)	29	10,614	1
2		Skilled Pediatric (SNF/PED)			2
3	90	Intermediate (ICF)	90	32,940	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	119	TOTALS	119	43,554	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,164	116	1,641	2,921	8
9	SNF/PED					9
10	ICF	21,389	3,088		24,477	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,553	3,204	1,641	27,398	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.91%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/72

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 9 and days of care provided 1641

Medicare Intermediary ADMINASTAR FEDERAL OF KENTUCKY

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	87,583	13,492	5,818	106,893		106,893	0	106,893			1
2	Food Purchase		97,019		97,019		97,019	(584)	96,435			2
3	Housekeeping	32,066	10,313		42,379		42,379	0	42,379			3
4	Laundry	25,324	11,670		36,994		36,994	0	36,994			4
5	Heat and Other Utilities			61,549	61,549		61,549	0	61,549			5
6	Maintenance	24,934	23,032	28,314	76,280		76,280	940	77,220			6
7	Other (specify):* UTILITY WORKE	26,509			26,509		26,509	0	26,509			7
8	TOTAL General Services	196,416	155,526	95,681	447,623		447,623	356	447,979			8
	B. Health Care and Programs											
9	Medical Director			13,200	13,200		13,200	0	13,200			9
10	Nursing and Medical Records	783,690	67,776	34,856	886,322	(37,933)	848,389	0	848,389			10
10a	Therapy	24,372	2,572	175,853	202,797	(175,853)	26,944	0	26,944			10a
11	Activities	35,848	1,951		37,799		37,799	0	37,799			11
12	Social Services			2,948	2,948		2,948	0	2,948			12
13	Nurse Aide Training							0				13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16	TOTAL Health Care and Programs	843,910	72,299	226,857	1,143,066	(213,786)	929,280		929,280			16
	C. General Administration											
17	Administrative	24,870		15,413	40,283	1,690	41,973	32,627	74,600			17
18	Directors Fees							0				18
19	Professional Services			183,579	183,579		183,579	(175,754)	7,825			19
20	Dues, Fees, Subscriptions & Promotions			20,971	20,971		20,971	(4,114)	16,857			20
21	Clerical & General Office Expenses	25,190	7,297	6,562	39,049		39,049	16,515	55,564			21
22	Employee Benefits & Payroll Taxes			170,090	170,090		170,090	9,484	179,574			22
23	Inservice Training & Education			2,728	2,728		2,728	109	2,837			23
24	Travel and Seminar			3,988	3,988	(3,547)	441	1,648	2,089			24
25	Other Admin. Staff Transportation							0				25
26	Insurance-Prop.Liab.Malpractice			78,957	78,957		78,957	302	79,259			26
27	Other (specify):*			57,317	57,317		57,317	(57,317)				27
28	TOTAL General Administration	50,060	7,297	539,605	596,962	(1,857)	595,105	(176,500)	418,605			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,090,386	235,122	862,143	2,187,651	(215,643)	1,972,008	(176,144)	1,795,864			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to inc

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			20,782	20,782		20,782	15,964	36,746			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			35,321	35,321		35,321	(17,984)	17,337			32
33	Real Estate Taxes			31,007	31,007		31,007	0	31,007			33
34	Rent-Facility & Grounds			178,500	178,500		178,500	(174,718)	3,782			34
35	Rent-Equipment & Vehicles							0				35
36	Other (specify):*							0				36
37	**TOTAL Ownership**			265,610	265,610		265,610	(176,738)	88,872			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers					215,643	215,643	0	215,643			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			65,332	65,332		65,332	0	65,332			42
43	Other (specify):*							0				43
44	**TOTAL Special Cost Centers**			65,332	65,332	215,643	280,975		280,975			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,090,386	235,122	1,193,085	2,518,593	0	2,518,593	(352,882)	2,165,711			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(5,923)	30		9
10	Interest and Other Investment Income	(2,749)	32		10
11	Discounts, Allowances, Rebates & Refunds	(63)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,271)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(281)	20		17
18	Fines and Penalties	(19,740)	27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,105)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(33,656)	27		24
25	Fund Raising, Advertising and Promotional	(3,264)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(797)	20		28
29	Other-Attach Schedule	(1,234)	VAR.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (76,083)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(277,182)	Various	34
35	Other- Attach Schedule Sch.XIXH-Column 8	383	6	35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (276,799)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (352,882)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39	Therapy	X		175,853	10a	39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology	X		1,981	10	42
43	Prescription Drugs	X		25,844	10	43
44	Exceptional Care Program					44
45	Other-Attach Schedule IV'S	X		5,784	10	45
46	Other-Attach Schedule OXY & SUPPI	X		6,181	10	46
47	TOTAL (C): (sum of lines 38-46)			$ 215,643		47

Print Preview

STATE OF ILLINOIS

Facility Name **D'ADRIAN CONVALESCENT CENTER**

ID# **0016147**

Report Period Beginning: **01/01/00**

Ending: **12/31/00**

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference
information listed in B13 thru G43 is from Page 5.		
Day Care	0	0
Other Care for Outpatients	0	0
Governmental Sponsored Special Programs	0	0
Non-Patient Meals	0	0
Telephone, TV & Radio in Resident Rooms	0	0
Rented Facility Space	0	0
Sale of Supplies to Non-Patients	0	0
Laundry for Non-Patients	0	0
Non-Straightline Depreciation	(5,923)	30
Interest and Other Investment Income	(2,749)	32
Discounts, Allowances, Rebates & Refunds	(63)	21
Non-Working Officer's or Owner's Salary	0	0
Sales Tax	(3,271)	27
Non-Care Related Interest	0	0
Non-Care Related Owner's Transactions	0	0
Personal Expenses (Including Transportation)	0	0
Non-Care Related Fees	(281)	20
Fines and Penalties	(19,740)	27
Entertainment	0	0
Contributions	0	0
Owner or Key-Man Insurance	0	0
Special Legal Fees & Legal Retainers	(5,105)	19
Malpractice Insurance for Individuals	0	0
Bad Debt	(33,656)	27
Fund Raising, Advertising and Promotional	(3,264)	20
Income & IL Personal Property ReplacementTaxes	0	0
Nurse Aide Training for Non-Employees	0	0
Yellow Page Advertising	(797)	20
Non-Paid Workers	0	0
Donated Goods	0	0
Amortization Expense	0	0
VENDING	(584)	2
SETTLEMENT	(650)	27

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(584)	0	0	0	0	0	0	0	0	0	0	(584)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(584)	0	0	0	0	0	0	0	0	0	0	(584)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	741	0	0	0	0	0	0	0	0	0	741	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,105)	(170,755)	0	0	0	0	0	0	0	0	0	(175,860)	19
20	Fees, Subscriptions & Promotions	(4,342)	150	0	0	0	0	0	0	0	0	0	(4,192)	20
21	Clerical & General Office Expenses	(63)	0	0	0	0	0	0	0	0	0	0	(63)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(741)	0	0	0	0	0	0	0	0	0	(741)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(57,317)	0	0	0	0	0	0	0	0	0	0	(57,317)	27
28	**TOTAL General Administration**	(66,827)	(170,605)	0	0	0	0	0	0	0	0	0	(237,432)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(67,411)	(170,605)	0	0	0	0	0	0	0	0	0	(238,016)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(5,923)	20,179	0	0	0	0	0	0	0	0	0	14,256	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,749)	(15,235)	0	0	0	0	0	0	0	0	0	(17,984)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(178,500)	0	0	0	0	0	0	0	0	0	(178,500)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(8,672)	(173,556)	0	0	0	0	0	0	0	0	0	(182,228)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(76,083)	(344,161)	0	0	0	0	0	0	0	0	0	(420,244)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
H. RAYMOND KLEIN	33.33	HILLTOP NURSING HOME	CHARLESTON	Nursing Home Mngrs	SPRINGFIELD	MANAGEMENT
LISA KLEIN GILDAR	5.56	JACKSONVILLE CONVALESCENT CENTER	JACKSONVILLE	D'Adrian Land Trust	SPRINGFIELD	LEASOR
DANA KLEIN	5.56	MEADOW MANOR	TAYLORVILLE			
PHILIP KLEIN	5.56	MENARD CONVALESCENT CENTER	PETERSBURG			
JERRY W. JENNINGS	8.33	SUNRISE MANOR OF VIRDEN	VIRDEN			
PAULA K. JENNINGS	8.33					
SAM KLEIN	33.33					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	MANAGEMENT FEE	$ 178,276	NURSING HOME MANAGERS, INC.	66.67%	$	$ (178,276)	1
2	V	Var.	SEE ATTACHED SCHEDULE		NURSING HOME MANAGERS, INC.		66,979	66,979	2
3	V	19	ACCOUNTING		NURSING HOME MANAGERS, INC.(DIRECT ALLOCATION)		7,521	7,521	3
4	V	24	TRAVEL	741	TO TRANSFER 31% OF HOME OFFICE TRAVEL			(741)	4
5	V	17	ADMINISTRATIVE TRAVEL		TO ADMINISTRATIVE (PER DESK AUDIT)		741	741	5
6	V								6
7	V								7
8	V	34	RENT	178,500	D'ADRIAN LAND TRUST	100.00%		(178,500)	8
9	V	30	DEPRECIATION		D'ADRIAN LAND TRUST		20,179	20,179	9
10	V	20	TRUST FEES		D'ADRIAN LAND TRUST		150	150	10
11	V	32	INTEREST INCOME		D'ADRIAN LAND TRUST		(15,235)	(15,235)	11
12	V								12
13	V								13
14	Total			$ 357,517			$ 80,335	$ * (277,182)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JERRY W. JENNINGS	SECRETARY	MANAGEMENT	8.33					$ 13,065	17-7	1
2	H. RAYMOND KLEIN	OWNER	MANAGEMENT	33.33					1,860	17-7	2
3	SAM KLEIN	PRESIDENT	MANAGEMENT	33.33					1,860	17-7	3
4											4
5		JERRY JENNINGS, SAMKLEIN, AND H. RAYMOND KLEIN WERE PAID BY									5
6		NURSING HOME MANAGERS, INC., A RELATED ORGANIZATION. TOTAL									6
7		COMPENSATION OF $10,010 FOR EACH SAM KLEIN AND H. RAYMOND KLEIN									7
8		WAS ALLOCATED AMONG THE SIX RELATED NURSING HOMES, BASED									8
9		UPON 10 HOURS PER WEEK FOR SAM KLEIN AND 10 HOURS PER WEEK FOR									9
10		H. RAYMOND KLEIN. FOR JERRY JENNINGS $70,304 OF COMPENSATION									10
11		WAS ALLOCATED AMONG THE RELATED HOMES BASED UPON 35 HOURS									11
12		PER WEEK.									12
13								TOTAL	$ 16,785		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Print Preview

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D | Show Pgs 8E thru 8I | Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NURSING HOME MANAGERS, INC.
Street Address: 2653 WEST LAWRENCE - SUITE B
City / State / Zip Code: SPRINGFIELD, IL 62704
Phone Number: (217) 787-8530
Fax Number: (217) 787-9840

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		SEE ATTACHED SCHEDULES				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	OWNERS	X		MORTGAGE	$3,000.00	01/01/1992	$ 350,000	$ 245,047	12/01/2010	08.00%	$ 20,293	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$3,000.00		$ 350,000	$ 245,047			$ 20,293	9
	B. Non-Facility Related*											
10	D'ADRIAN LAND TRUST	X		WORKING CAPITAL(SEE ATTACHED SCH		12/16/97	120,000	403,226	DEMAND	06.00%	15,028	10
11	SAM KLEIN	X		WORKING CAPITAL		12/28/00	30,000	30,000	DEMAND	06.00%	0	11
12												12
13												13
14	TOTAL Non-Facility Related						$ 150,000	$ 433,226			$ 15,028	14
15	TOTALS (line 9+line14)						$ 500,000	$ 678,273			$ 35,321	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Preview

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	29,893	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	30,450	2
3. Under or (over) accrual (line 2 minus line 1).	$	557	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	30,450	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ _____ For 19 ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	31,007	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	31,596	8
	1996	33,768	9
	1997	35,462	10
	1998	29,893	11
	1999	30,450	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Print Preview

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,520 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1971	$ 90,753	1
2	ADJUST TO PRIOR COST REPORTS			(4,261)	2
3	TOTALS			$ 86,492	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	119		1972	1972	$ 762,167	$ 5,777	30	$ 4,304	$ (1,473)	$ 762,167	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	AIR CONDITIONER			1979	606		8			606	9
10	ROOF			1980	14,809		15			14,809	10
11	AIR CONDITIONER			1980	2,409		8			2,409	11
12	AIR CONDITIONER			1982	2,420		15			2,420	12
13	IMPROVEMENTS			1983	15,356		15			15,356	13
14	AIR CONDITIONER			1984	1,597		15			1,597	14
15	WATER HEATER			1984	5,216	19	15		(19)	5,216	15
16	IMPROVEMENTS			1985	13,452	486	15	521	35	13,452	16
17	IMPROVEMENTS			1986	11,941	422	15	796	374	11,542	17
18	WINDOWS			1987	5,150	109	15	343	234	4,631	18
19	WINDOWS & SIGN			1988	4,235	90	15	282	192	3,525	19
20	HEAT EXCHANGER			1989	1,833	39	15	122	83	1,403	20
21	IMPROVEMENTS			1990	8,489	180	15	566	386	5,943	21
22	FIRE DAMPERS			1991	9,877	209	15	658	449	6,580	22
23	ROOF			1991	10,563	224	20	528	304	5,016	23
24	WINDOWS			1991	1,050	33	15	70	37	653	24
25	ROOF			1991	40,303	1,280	20	2,015	735	18,807	25
26	AIR CONDITIONER & WINDOWS			1992	3,833	122	15	256	134	2,176	26
27	ROOF			1992	17,724	562	20	886	324	7,974	27
28	PLUMBING & HEATING			1993	11,432	362	15	762	400	5,715	28
29	SIDEWALK & CURB (PER DESK REVIEW)			1990	1,292		20	65	65	455	29
30	NON-ALLOWABLE DUE TO OWNERSHIP CHANGE					9,260			(9,260)		30
31	WINDOWS & HEAT EXCHANGER			1995	13,372	343	15	892	549	4,906	31
32	ROOF			1995	25,820	662	20	1,291	629	7,101	32
33	DOORS, PARKING LOT, & NURSE CALL			1997	20,175	517	15	1,345	828	4,708	33
34	AIR CONDITIONER & HEATING UNITS			1998	18,783	482	15	1,252	770	3,130	34
35	GAS VALVE & DOOR FRAMES			1999	2,542	65	15	169	104	251	35
36	TOTAL (lines 4 thru 35)				$ 1,026,446	$ 21,243		$ 17,123	$ (4,120)	$ 912,548	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	REMODEL ROOM #102			2000	1,769	44	15	118	74	118	9
10	WATER HEATER			2000	17,720	361	15	986	625	986	10
11	DRIVEWAY			2000	18,076	174	15	502	328	502	11
12	FIRE ALARM CONTROL PANEL			2000	2,751	15	15	46	31	46	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 40,316	$ 594		$ 1,652	$ 1,058	$ 1,652	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12B

STATE OF ILLINOIS

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 162,339	$ 17,207	$ 15,529	$ (1,678)	VARIOUS	$ 72,587	37
38	Current Year Purchases	13,419	1,917	734	(1,183)	VARIOUS	734	38
39	Fully Depreciated Assets	199,277					199,277	39
40	Less Assets no Longer in Service	(117,204)					(117,204)	40
41	TOTALS	$ 257,831	$ 19,124	$ 16,263	$ (2,861)		$ 155,394	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 1,411,085	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 40,961	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 35,038	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (5,923)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,069,594	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: D'ADRIAN LAND TRUST

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1972	119		$ 178,500			3
4	Additions							4
5								5
6								6
7	TOTAL		119		$ 178,500 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 01/01/00
Ending 12/31/00

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/01	$ 178,500
13.	12/31/02	$ 178,500
14.	12/31/03	$ 178,500

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ Description: INCLUDED IN THE ABOVE AMOUNT
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Preview

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$	1,197	$ 58,644	$	1,197	$ 58,644	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		950	47,494		950	47,494	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		1,651	69,715		1,651	69,715	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	10-2	# of prescrpts				25,844		25,844	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	IV'S, MEDICAL SUPPLIES, OXYGEN Other (specify): LABS & X-RAYS	10-2 10-2					11,965 1,981		11,965 1,981	13
14	TOTAL			$	3,798	$ 175,853	$ 39,790	3,798	$ 215,643	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 19,608	$ 24,369	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	308,745	308,745	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	49,370	49,370	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 377,723	$ 382,484	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		90,753	13
14	Buildings, at Historical Cost		985,267	14
15	Leasehold Improvements, at Historical Cost	81,816	81,816	15
16	Equipment, at Historical Cost	226,393	345,321	16
17	Accumulated Depreciation (book methods)	(183,154)	(965,017)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 125,055	$ 538,140	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 502,778	$ 920,624	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 65,089	$ 65,089	26
27	Officer's Accounts Payable	30,000	30,000	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	403,226		29
30	Accrued Salaries Payable	26,321	26,321	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,831	16,831	31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,450	30,450	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 571,917	$ 168,691	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	245,047	245,047	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 245,047	$ 245,047	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 816,964	$ 413,738	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (314,186)	$ 506,886	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 502,778	$ 920,624	48

***(See instructions.)**

Print Preview

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (130,028)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (130,028)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(184,158)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (184,158)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (314,186)	24 *

*** This must agree with page 17, line 47.**

Print Preview

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,228,452	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,228,452	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	101,492	6
7	Oxygen	30	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 101,522	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	540	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 540	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,749	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,749	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING $584, ADMIT FEES $525	1,109	28
28a	WAGE/ASSIGNMENT $63	63	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,172	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,334,435	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 447,623	31
32	Health Care	1,143,066	32
33	General Administration	596,962	33
	B. Capital Expense		
34	Ownership	265,610	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	65,332	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,518,593	40
41	**Income before Income Taxes (line 30 minus line 40)****	(184,158)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (184,158)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Print Preview

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,760	1,870	$ 36,667	$ 19.61	1
2	Assistant Director of Nursing	741	770	12,337	16.02	2
3	Registered Nurses	4,943	5,113	80,396	15.72	3
4	Licensed Practical Nurses	15,024	15,467	173,992	11.25	4
5	Nurse Aides & Orderlies	50,187	51,209	480,298	9.38	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,807	2,007	24,372	12.14	8
9	Activity Director	1,864	1,957	15,034	7.68	9
10	Activity Assistants	3,438	3,488	20,814	5.97	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,333	2,452	25,006	10.20	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,782	10,195	62,577	6.14	15
16	Dishwashers					16
17	Maintenance Workers	3,692	3,849	24,934	6.48	17
18	Housekeepers	5,233	5,445	32,066	5.89	18
19	Laundry	4,056	4,083	25,324	6.20	19
20	Administrator	1,200	1,216	24,870	20.45	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,987	3,054	25,190	8.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Utility Workers	4,574	4,624	26,509	5.73	33
34	TOTAL (lines 1 - 33)	113,619	116,798	$ 1,090,386 *	$ 9.34	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	188	$ 5,818	1-3	35
36	Medical Director	120	13,200	9-3	36
37	Medical Records Consultant	16	632	10-3	37
38	Nurse Consultant	292	11,695	10-3	38
39	Pharmacist Consultant	48	900	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	60	2,948	12-3	45
46	Other(specify)				46
47	ADMINISTRATIVE CONSULTAN	673	15,413	17-3	47
48					48
49	TOTAL (lines 35 - 48)	1,397	$ 50,606		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	1,268	21,629	10-3	52
53	TOTAL (lines 50 - 52)	1,268	$ 21,629		53

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DAVID PORTO	ADMINISTRATOR	0.00%	$ 11,850
RACHEL GANSZ	ADMINISTRATOR	0.00%	5,390
GAIL SHAW	ADMINISTRATOR	0.00%	7,630
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 24,870

B. Administrative - Other

Description	Amount
ADMINISTRATIVE CONSULTANT	$ 15,413
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 15,413

C. Professional Services

Vendor/Payee	Type	Amount
Nursing Home Managers, Inc.	MANAGEMENT	$ 178,276
Feldman, Wasser, Draper & Benson	LEGAL	4,405
C S C	CORP. REPRESENTATION	198
Duane, Morris & Heckscher	LEGAL	700
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 183,579

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 39,829
Unemployment Compensation Insurance	23,131
FICA Taxes	82,070
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
SECTION 125 - CAFETERIA PLAN	18,823
HBV VACCINE	182
EMPLOYEE LIFE INSURANCE	1,979
GIFT CERTIFICATES	1,900
EMPLOYEE PARTIES	712
EMPLOYEE APPRECIATION	1,464
NURSING HOME MANAGERS ALLOC.	9,484
TOTAL (agree to Schedule V, line 22, col.8)	$ 179,574

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
HBV VACCINE	22	$ 182
GIFT CERTIFICATES	22	1,900
EMPLOYEE PARTIES	22	712
EMPLOYEE APPRECIATION	22	1,464
TOTAL		$ 4,258

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	15,657
Health Care Worker Background Check	792
(Indicate # of checks performed 66)	
SEE ATTACHED SCHEDULE	4,522
D'ADRIAN LAND TRUST - TRUST FEES	150
NURSING HOME MANAGERS ALLOC.	78
LESS: Non-allowable fees	(281)
Less: Public Relations Expense	(3,264)
Non-allowable advertising	( )
Yellow page advertising	(797)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,857

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
ADMINISTRATOR TRAVEL	203
MISCELLANEOUS TRAVEL REIMB.	238
NURSING HOME MANAGERS ALLOC.	1,648
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,089

* Attach copy of IMRF notifications

**See instructions.

Print Preview

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
					Amount of Expense Amortized Per Year								
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	COMPRESSORS	VAR '89	$ 2,328	3 YR	$	$	$	$	$	$	$	$	$
2	COMPRESSORS	VAR '90	3,784	3 YR									
3	PAINT	VAR '92	1,515	3 YR									
4	PAINT & WALLPAPE	VAR '93	4,128	3 YR									
5	PAINT & WALLPAPE	VAR '94	1,774	3 YR	296								
6	PAINT & WALLPAPE	VAR '95	3,152	3 YR	1,051	525							
7	PAINT & WALLPAPE	VAR '96	1,814	3 YR	605	605	302						
8	PAINT & WALLPAPE	VAR '97	2,301	3 YR	384	767	767	383					
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 20,796		$ 2,336	$ 1,897	$ 1,069	$ 383	$	$	$	$	$

Print Preview

Facility Name & ID Number D'ADRIAN CONVALESCENT CENTER # 0016147 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 13 YEARS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 978 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 65,332
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? YES If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ 0

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Print Preview

SCHEDULE V - PAGE 3 & 4

LINE 27 - COLUMN 3 - GENERAL ADMINISTRATIVE - OTHER

SALES TAX	$	3271
BAD DEBT		33656
FINES		19740
SETTLEMENT		650
	$	57317

COLUMN 5 - DETAIL OF RECLASSIFICATIONS

			LINE
RECLASS FROM:			
PHYSICAL THERAPY	$	-69715	10a
SPEECH THERAPY		-47494	10a
OCCUPATIONAL THERAPY		-58644	10a
OXYGEN		-3152	10
MEDICARE DRUGS		-25844	10
MEDICARE SUPPLIES		-3029	10
X - RAYS		-948	10
LABORATORY		-1033	10
I V THERAPY		-5784	10
RECLASS TO:			
ANCILLARY SERVICES	$	215643	39
RECLASS TO:			
NURSE CONS. MILEAGE REIMB.	$	1857	10
ADMINISTRATIVE TRAVEL REIMB.		1690	17
RECLASS FROM:			
TRAVEL	$	-3547	24

LINE 23 - DETAIL OF INSERVICE TRAINING & EDUCATION

FOOD SERVICE SUPERVISOR COURSE	$	573
ACTIVITY WORKSHOP & CLASS		962
C P R CLASS		470
DENTAL INSERVICE		500
EDUCATIONAL MATERIAL		223
PAGE 3 - LINE 23 - COLUMN 3	$	2728
NURSING HOME MANAGERS ALLOC.		109
PAGE 3 - LINE 23 - COLUMN 8	$	2837

LINE 24 - DETAIL OF TRAVEL & SEMINAR

NURSING CONSULTANT MILEAGE	$	1857
ADMINISTRATIVE CONSULT. MILEAGE		1690
ADMINISTRATOR MILEAGE REIMB.		203
MISCELLANEOUS MILEAGE REIMB.		238
PAGE 3 - LINE 24 - COLUMN 3	$	3988
RECLASS: NURSE CONSULT MILEAGE		-1857
RECLASS: ADMIN. CONSULT MILEAGE		-1690
NURSING HOME MANAGERS ALLOC.		1648
PAGE 3 - LINE 24 - COLUMN 8	$	2089

SCHEDULE IX - PAGE 9

LINE 10 - COLUMN 10
$15,028 IS OFFSET ON SCHEDULE VII - PAGE 6 - PART B - LINE 11 LAND TRUST TRANSACTIONS AND THEREFORE IS NOT INCLUDED ON SCHEDULE VI - PAGE 5 - LINE 14

SCHEDULE XI - PAGE 13 - SECTION E

RECONCILIATION OF DEPRECIATION

PAGE 13 - LINE 49	$	35038
NURSING HOME MANAGERS ALLOC.		1708
SCHEDULE V - LINE 30 - COLUMN 8	$	36746

SCHEDULE XVII - PAGE 19 - LINE 43

RECONCILIATION OF INCOME

PAGE 19 - LINE 43	$	-184158
*ACCRUED MANAGEMENT FEE 12/99		-13586
*ACCRUED MANAGEMENT FEE 12/00		19659
INTEREST INCOME PASSED DIRECTLY TO OWNERS		-2749
TAXABLE INCOME	$	-180834

*RELATED PARTY ACCOUNTS PAYABLE NOT ALLOWED FOR TAX PURPOSES INCLUDED HERE FOR CONSISTENCY WITH PRIOR COST REPORTS AND TO CONFORM TO ACCRUAL ACCOUNTING METHODS.

SCHEDULE XIX - PAGE 21 - SECTION F

DUES, FEES, SUBSCRIPTIONS, AND PROMOTIONS

YELLOW PAGES	$	797
PUBLIC RELATIONS		3264
LOCAL BUSINESS COUNCILS		131
FRANCHISE FEES		105
HCFA LAB FEES		150
ADMINISTRATOR LICENSE		75
	$	4522

SCHEDULE XX - PAGE 23 - QUESTION 12

SALARY COST IS ALLOCATED TO DEPARTMENT WORKED BASED UPON TIME CARDS.

CENTRAL OFFICE COST ALLOCATION
D'ADRIAN
2000

	JAN	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
SALARIES-ADMIN	$2,762	$2,620	$2,588	$2,577	$2,637	$2,626	$2,632	$1,915	$1,906	$1,919	$2,012	$1,972	$28,166
SALARIES-CLERIC	1,417	1,344	1,328	1,322	1,353	1,347	1,350	1,010	1,005	1,012	1,062	1,041	14,590
SALARIES-ACTIV	0	0	0	0	0	0	0	0	0	0	0	0	0
SALARIES-NURSE	0	0	0	0	0	0	0	0	0	0	0	0	0
ACCOUNTING	9	9	8	8	9	9	9	9	9	9	10	9	106
WORK COMP INS	15	14	14	14	14	14	14	24	24	24	25	25	220
SUPPLIES	134	128	126	125	128	128	128	37	37	37	39	38	1,085
TELEPHONE	64	61	60	60	61	61	61	94	93	94	98	97	903
EMPL BENEFITS	456	433	428	426	436	434	435	505	503	506	531	520	5,613
PAYROLL TAXES	340	322	318	317	324	323	324	272	271	273	286	281	3,651
TRAVEL	195	185	183	182	186	185	186	214	213	215	225	221	2,389
IN SERVICE	13	13	12	12	13	13	13	4	4	4	4	4	109
MEDICAL CONSULT	0	0	0	0	0	0	0	0	0	0	0	0	0
MACHINE RENTAL	21	20	20	20	20	20	20	(0)	(0)	(0)	(0)	(0)	141
OWNERS COMP	324	307	304	302	309	308	309	307	305	307	322	316	3,720
INS-PROP,LIAB,WC	24	22	22	22	22	22	22	29	28	29	30	29	302
DEPRECIATION	150	143	141	140	144	143	143	139	138	139	146	143	1,708
RENT	333	316	312	311	318	317	317	307	306	308	323	316	3,782
MAINTENANCE	27	26	25	25	26	26	26	46	46	47	49	48	416
FEES & PUBLICAT	5	5	5	5	5	5	5	5	5	5	5	5	60
ADVERTISING	3	3	2	2	3	3	3	0	0	0	0	0	18
	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	6,291	5,968	5,896	5,871	6,007	5,982	5,996	4,917	4,893	4,927	5,167	5,064	$66,979
FIXED ASSETS													66,978
EQUIP - PRIOR	9,014	8,550	8,447	8,412	8,606	8,571	8,591	8,311	8,272	8,328	8,734	8,560	8,533
EQUIP - CURR	1,824	2,100	3,889	3,873	3,962	3,946	3,955	3,826	3,808	3,834	4,021	3,941	3,582
EQUIP - FULLY DEP	1,102	1,046	1,033	1,029	1,052	1,048	1,051	1,016	1,011	1,018	1,068	1,047	1,043
BLDG - PRIOR	1,320	1,252	1,237	1,232	1,261	1,255	1,258	1,217	1,212	1,220	1,279	1,254	1,250
BLDG - CURR	0	0	0	0	0	0	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0	0	0	0	0	0	0

COST ALLOCATION
JULY 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.71%	14.72%	19.35%	20.17%	11.78%	15.26%	100.00%
SALARIES-ADMIN	$2,632	$2,071	$2,722	$2,838	$1,657	$2,146	$14,066
SALARIES-CLERIC	1,350	1,062	1,396	1,456	850	1,101	7,216
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	0	0	0	0	0	0
ACCOUNTING	9	7	9	9	5	7	46
WORK COMP INS	14	11	15	15	9	11	75
SUPPLIES	128	101	133	138	81	104	685
TELEPHONE	61	48	63	66	38	50	326
EMPL BENEFITS	435	342	450	469	274	355	2,324
PAYROLL TAXES	324	255	335	349	204	264	1,730
TRAVEL	186	146	192	200	117	151	993
IN SERVICE	13	10	13	14	8	10	68
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	20	16	21	22	13	16	108
OWNERS COMP	309	243	319	333	194	252	1,650
INS-PROP,LIAB,WC	22	18	23	24	14	18	120
DEPRECIATION	143	113	148	155	90	117	766
RENT	317	250	328	342	200	259	1,696
MAINTENANCE	26	20	27	28	16	21	137
FEES & PUBLIC	5	4	5	5	3	4	25
ADVERTISING	3	2	3	3	2	2	13
	0	0	0	0	0	0	0
TOTAL	$5,996	$4,718	$6,201	$6,465	$3,776	$4,889	$32,044
FIXED ASSETS							
EQUIP - PRIOR	8,591	6,760	8,884	9,262	5,410	7,004	45,912
EQUIP - CURR	3,955	3,112	4,090	4,264	2,491	3,225	21,138
EQUIP - FULLY DEP	1,051	827	1,086	1,133	662	856	5,614
BLDG - PRIOR	1,258	990	1,301	1,357	792	1,026	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
AUGUST 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.10%	14.62%	18.85%	20.40%	12.20%	15.82%	100.00%
SALARIES-ADMIN	$1,915	$1,547	$1,994	$2,158	$1,291	$1,674	$10,578
SALARIES-CLERIC	1,010	816	1,052	1,138	681	883	5,581
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	0	0	0	0	0	0
ACCOUNTING	9	7	9	10	6	8	50
WORK COMP INS	24	19	25	27	16	21	132
SUPPLIES	37	30	38	42	25	32	204
TELEPHONE	94	76	98	106	63	82	518
EMPL BENEFITS	505	408	526	569	341	442	2,791
PAYROLL TAXES	272	220	284	307	184	238	1,505
TRAVEL	214	173	223	241	144	187	1,183
IN SERVICE	4	3	4	5	3	4	22
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	(0)	(0)	(0)	(0)	(0)	(0)	(0)
OWNERS COMP	307	248	319	346	207	268	1,694
INS-PROP,LIAB,WC	29	23	30	32	19	25	158
DEPRECIATION	139	112	144	156	93	121	765
RENT	307	248	320	346	207	268	1,696
MAINTENANCE	46	38	48	52	31	41	257
FEES & PUBLIC	5	4	5	5	3	4	26
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$4,917	$3,972	$5,120	$5,540	$3,314	$4,298	$27,160
FIXED ASSETS							
EQUIP - PRIOR	8,311	6,715	8,655	9,364	5,602	7,265	45,912
EQUIP - CURR	3,826	3,091	3,985	4,311	2,579	3,345	21,138
EQUIP - FULLY DEP	1,016	821	1,058	1,145	685	888	5,614
BLDG - PRIOR	1,217	984	1,268	1,372	821	1,064	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
SEPTEMBER 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.02%	14.91%	18.11%	19.77%	13.38%	15.82%	100.00%
SALARIES-ADMIN	$1,906	$1,577	$1,915	$2,092	$1,415	$1,673	$10,578
SALARIES-CLERIC	1,005	832	1,011	1,104	747	883	5,581
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	0	0	0	0	0	0
ACCOUNTING	9	7	9	10	7	8	50
WORK COMP INS	24	20	24	26	18	21	132
SUPPLIES	37	30	37	40	27	32	204
TELEPHONE	93	77	94	102	69	82	518
EMPL BENEFITS	503	416	505	552	373	441	2,791
PAYROLL TAXES	271	224	273	298	201	238	1,505
TRAVEL	213	176	214	234	158	187	1,183
IN SERVICE	4	3	4	4	3	4	22
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	(0)	(0)	(0)	(0)	(0)	(0)	(0)
OWNERS COMP	305	253	307	335	227	268	1,694
INS-PROP,LIAB,WC	28	24	29	31	21	25	158
DEPRECIATION	138	114	139	151	102	121	765
RENT	306	253	307	335	227	268	1,696
MAINTENANCE	46	38	46	51	34	41	257
FEES & PUBLIC	5	4	5	5	3	4	26
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$4,893	$4,049	$4,918	$5,371	$3,633	$4,296	$27,160
FIXED ASSETS							
EQUIP - PRIOR	8,272	6,845	8,314	9,078	6,141	7,262	45,912
EQUIP - CURR	3,808	3,152	3,828	4,180	2,828	3,343	21,138
EQUIP - FULLY DEP	1,011	837	1,017	1,110	751	888	5,614
BLDG - PRIOR	1,212	1,003	1,218	1,330	900	1,064	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

ALLOCATION PERCENTAGES
USED ON MONTHLY ALLOCATIONS - PAGE 27

OCCUPIED DAYS 2000	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	2,453	1,828	2,186	1,874	663	1,482	2,008	12,494
FEBRUARY	2,205	1,686	2,168	1,746	597	1,442	1,996	11,840
MARCH	2,383	1,773	2,434	1,904	604	1,569	2,285	12,952
APRIL	2,273	1,671	2,387	1,783	641	1,496	2,155	12,406
MAY	2,301	1,691	2,252	1,910	600	1,448	2,073	12,275
JUNE	2,211	1,730	2,175	1,793	603	1,426	1,906	11,844
JULY	2,317	1,823	2,396	1,846	652	1,459	1,889	12,382
AUGUST	2,249	1,817	2,342	1,861	673	1,516	1,966	12,424
SEPTEM	2,163	1,790	2,174	1,709	665	1,606	1,899	12,006
OCTOBER	2,249	1,815	2,246	1,709	627	1,766	1,986	12,398
NOVEMBEI	2,288	1,675	2,189	1,590	594	1,689	2,002	12,027
DECEMBEI	2,294	1,678	2,228	1,642	668	1,664	2,130	12,304
TOTAL	27,386	20,977	27,177	21,367	7,587	18,563	24,295	147,352
								147,352

ALLOCATION PERCENTAGE 2000	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	19.63%	14.63%	17.50%	20.31%	11.86%	16.07%	100.00%
FEBRUARY	18.62%	14.24%	18.31%	19.79%	12.18%	16.86%	100.00%
MARCH	18.40%	13.69%	18.79%	19.36%	12.11%	17.64%	100.00%
APRIL	18.32%	13.47%	19.24%	19.54%	12.06%	17.37%	100.00%
MAY	18.75%	13.78%	18.35%	20.45%	11.80%	16.89%	100.00%
JUNE	18.67%	14.61%	18.36%	20.23%	12.04%	16.09%	100.00%
JULY	18.71%	14.72%	19.35%	20.17%	11.78%	15.26%	100.00%
AUGUST	18.10%	14.62%	18.85%	20.40%	12.20%	15.82%	100.00%
SEPTEMBER	18.02%	14.91%	18.11%	19.77%	13.38%	15.82%	100.00%
OCTOBER	18.14%	14.64%	18.12%	18.84%	14.24%	16.02%	100.00%
NOVEMBER	19.02%	13.93%	18.20%	18.16%	14.04%	16.65%	100.00%
DECEMBER	18.64%	13.64%	18.11%	18.77%	13.52%	17.31%	100.00%